

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/20/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>155102</b>		(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>02</b> B. WING _____		(X3) DATE SURVEY COMPLETED  <b>01/17/2012</b>	
NAME OF PROVIDER OR SUPPLIER  <b>MILLER'S MERRY MANOR</b>				STREET ADDRESS, CITY, STATE, ZIP CODE <b>635 OAKHILL AVE PLYMOUTH, IN 46563</b>			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K 000	<p>INITIAL COMMENTS</p> <p>A Life Safety Code and Preoccupancy Survey for a bed relocation of 2 comprehensive care beds to room 62 was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 01/17/12</p> <p>Facility Number: 000041 Provider Number: 155102 AIM Number: 100275400</p> <p>Surveyor: Richard D. Schade, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Miller's Merry Manor was found in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2-3.1-19, Environment and Physical Standards of the Indiana Health Facilities Rules for Comprehensive care facilities.</p> <p>This one story facility determined to be of Type V (000) construction and was fully sprinklered. The building was constructed in three phases: the original building in 1968 which includes the Terrace wing, ICF I and II; ICF III and the Skilled wing completed in 1974; and the Orchard wing and main hall added in 1985. The facility has a fire alarm system with smoke detection in the corridors, resident sleeping rooms and spaces open to the corridors. The facility has a capacity</p>			K 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 000	Continued From page 1 of 135 and room 62 had a census of 0 at the time of this survey.  Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 01/19/12.			K 000			